MARIMN HEALTH
COEUR D'ALENE TRIBE

Dear Patient,

Welcome to Marimn Health! We are happy to serve you as a new patient. To make your visit with us more pleasant, please complete the registration information. We do require that you bring in the necessary items listed below so we are able to register you in our practice.

All patients must present the following:

- Picture ID
- Current medical/dental insurance eligibility cards, including Medicaid and Medicare

In order to establish eligibility for Indian Health Services, Native American applicants must also present the following:

- Tribal Enrollment Card or Certificate of Indian Blood
- If a descendant, a letter of descendancy from your affiliated tribe or a birth certificate and a copy of parents' tribal information

To establish eligibility for our Sliding Fee Program, please bring a copy of your most recent tax return and documentation of your place of residence.

Patients are responsible to pay in full for services received unless Marimn Health is provided appropriate documentation establishing Indian Health Service and/or the Sliding Fee Program. We expect payment at time of service of any co-pays, deductibles, and co-insurance.

It is important that you provide your signature at the bottom of the first page, the acknowledgement of receipt, and the self determination sections.

Thank you for your cooperation,

Marimn Health
First Impressions Department

Last Updated: 11/2017

P: 208.686.1931 F: 208.686.0213 marimnhealth.org PO Box 388 | 427 N. 12th Street | Plummer, ID 83851

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Patient Information

Patient Name: ____
(Last) (First) (Middle)

Gender (at birth):
☐ Male
☐ Female

Patient Address:____
(P.O. Box) (Street Address)

____
(City) (State) (Zip)

Home Phone: (_________) __________ - _________ Cell Phone: (_______) ____________ -____________

Email: _________________________________

Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Text Message ☐ Email

Date of Birth: _____ / _____ / ______ Social Security Number: ________ - ________ - __________

Employer Name: ____ Phone: (_____) ________ - __________

Emergency Contact: ________________________________ Phone: (_____) ________ - __________

Relationship to patient: _____________________________

Mother's Name: ____ Phone: (___) ____ - _______________

Father's Name: ____ Phone: (___) _____ - _______________

Race: ☐ American Indian ☐ Caucasian ☐ Asian ☐ African American ☐ Other Veteran: YES NO

Are you a member or descendant of a Federally Recognized Tribe? ☐ Yes ☐ No Tribe Name _______________

Is this visit due to an accident or injury while at your work place? ☐ Yes ☐ No

Primary Insurance: ____ ☐ Medical ☐ Dental ☐ Rx

Secondary Insurance: ____ ☐ Medical ☐ Dental ☐ Rx

*If you have insurance coverage, it must be billed before Indian Health funds are applied. As a courtesy, we will bill your insurance for services rendered at Marimn Health. The patient or legal guardian is responsible for payment of all services not covered by Indian Health or by your insurance.

*I AUTHORIZE MARIMN HEALTH TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING ILLNESS AND TREATMENT AND I HEREBY ASSIGN TO THE PHYSICAN AND CLINIC ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDANTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. STATEMENTS MAY BE SENT AS A COURTESY BUT PAYMENT IN FULL IS EXPECTED AT THE TIME OF SERVICE. PAYMENT IN FULL MAY BE DEMANDED AT ANY TIME.

*I REQUEST AND CONSENT TO TREATMENT AT MARIMN HEALTH, INCLUDING MEDICAL, DENTAL, COUNSELING, SUBSTANCE ABUSE, PHARMACY, AND ANY OTHER SERVICE OFFERED AT THE CLINIC OR WELLNESS CENTER. FURTHERMORE, I AUTHORIZE MY PROVIDER AND ANY OTHER PROVIDER WHO MAY ATTEND TO ME, THEIR ASSISTANTS, NURSES, AND ANY OTHER IN-HOUSE STAFF TO PROVIDE THE SERVICES DEEMED NECESSARY BY MY PROVIDER.

*IN CONSENTING TO TREATMENT, I UNDERSTAND THAT RESULTS OF MEDICAL TREATMENT VARY AND I HAVE NOT BEEN GUARANTEED SPECIFIC RESULTS.

SIGNATURE: ____ DATE: ________

Front Desk Staff Only:
MR #: ________________ Initials: ________

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NEW PATIENT HEALTH HISTORY

Name:____________________________________**DOB:**_____________________**Phone number:**____________________

Main reason for visit:____
____
____
____

Current personal medical history (e.g. diabetes, high blood pressure):
____
____
____
____
____

Allergies: (Include medications, food, and material allergies such as latex)

Allergy	Type of Reaction (rash, swelling, etc)

Current Medications INCLUDING prescribed medications, vitamins, supplements, non-prescription medications

Medication	Dosage/# of times a day	Do you need a refill? How many days left of medication?

Please list other medical providers you have seen in the last 2 years:
____
____
____

Please bring the following to your appointment:

- Your medications, supplements, and non-prescription drugs
- Immunization records
- A signed Release of Information form (attached)

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Patient Self-Determination

The patient Self-Determination Act is a law passed in 1990. It states that clinics that get Medicare or Medicaid funding are required to offer patients information on the Advanced Directive, such as a living will or durable power of attorney, and we are required to ask if a patient already has an Advanced Directive in place.

☐ I do ☐ I don't currently have an Advanced Directive in place.

If you would like more information on Advanced Directive, please ask your provider for an information packet.

Demographic Information

The following information helps Marimn Health with funding from several grant sources which better enables us to provide quality care within our communities. We would greatly appreciate it if you would take the time to complete the information requested.

Please circle the answer that best describes you and your family.

Family Size: 1 2 3 4 5 6 7 8 Other: _______

Family Income:	Under $13,000	$13,000-$20,000	$20,000-$30,000
	$30,000-$40,000	$40,000-$50,000	$50,000-$60,000
	$60,000-$70,000	$70,000-$80,000	Over $80,000

Our funding agreements with the federal government require that we report on the ethnic consideration of Hispanic or Non-Hispanic heritage. If you consider yourself to be Hispanic heritage, please circle "Hispanic". If not, please circle "Non-Hispanic".

I Consider Myself Primarily: Hispanic Non-Hispanic

SIGNATURE: ____ **DATE**: ______________________

MR #:_____________

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

We may use and disclose your personal health information:

- For treatment activities, both at Marimn Health and to referring doctors
- To bill for your services
- To conduct our day-to-day business and service operations
- Marimn Health participates in the Idaho Health Data Exchange where other health care providers involved in your care may access your health information.
- To give appointment reminders via phone and mail
- To provide interpretation services, if needed
- To inform you of helpful health-related services and treatment alternatives provided that we do not receive payment for these communications
- To keep friends, family members or personal representatives who are involved in your care or payment for your care informed, as long as you have agreed to this disclosure.
- To funding agencies as required by law and who support your care such as Indian Health Service, Bureau of Primary Health Care, Purchased and Referred Care, Veterans Administration, etc.
- To avert a serious threat to health or safety
- For worker's compensation claims
- For public health protection interventions as required by law
- As required for lawsuits and legal disputes
- To law enforcement as required by law
- To coroners, health examiners and funeral directors
- To national security, intelligence agencies, and protective services as required by law
- To certain specialized government functions, e.g. military, prisons, etc.
- Other uses and disclosures not included in our *Notice of Privacy Practices* will be made only with your written authorization

Your Rights:

- You have a right to be informed of our privacy practices, and to request a copy of the complete *Notice of Privacy Practices* handout
- To inspect and copy your personal health information. You have the right to request an electronic or paper copy of your health information records
- To request amendment of your health information records
- To receive an accounting of disclosures of your health information
- To request restrictions on the uses or disclosures of your health information
- To receive confidential communications by alternative means or at alternative locations
- To receive notification if there is an unauthorized disclosure of your protected health information
- To choose someone to act for you
- To choose to opt out of having your health information shared with the Idaho Health Data Exchange
- To file a complaint without threat of retaliation if you believe your privacy rights have been violated. For assistance, please contact the Quality Improvement Coordinator at (208)686-1931 ext.219.

PATIENT ACKNOWLEDGEMENT OF RECEIPT:

I, ______________________________________, hereby acknowledge that I have read and understand this Notice of Privacy Practices.

SIGNATURE: ____ DATE: _________

MR #:______________